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August 2, 2002

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Dear Provider:

This letter provides important information about changes to the Medicaid Pharmacy Program, including the implementation of new drug prior authorization (PA) requirements.

Granulocyte Colony Stimulating Factors: Leukine, Neulasta, Neupogen

- Effective September 10, 2002, all granulocyte colony stimulating factors (i.e., Leukine, Neulasta, and Neupogen) will require prior authorization.

- Refillable prescriptions which were written prior to September 10, 2002, and which otherwise would require prior authorization beginning September 10, 2002, may be refilled without prior authorization through November 30, 2002; however, prior authorization will be required thereafter.

- The following cost information based on Average Wholesale Price (AWP) is provided to show a relative comparison of the cost of drugs but does not represent the actual cost to Medicaid. Actual cost per day will be dependent on the daily dosage and frequency.

Brand Name	Strength	Dosage Form	AWP Per Unit
Neupogen	480 mcg/1.6ml	Vial	$196.94
Neupogen	300 mcg/ml	Vial	$197.80
Leukine	500 mcg/ml	Vial	$305.91
Neulasta	6 mg/0.6ml	Disposable Syringe	$2950.00

Drugs for Onychomycosis: Penlac; Oral forms of Lamisil and Sporanox; Griseofulvin

- Effective September 10, 2002, oral forms of Lamisil and Sporanox will require prior authorization and will be subject to the following limits:

    - Lamisil: For onychomycosis, there will be a quantity limit of 28 tablets per 4 weeks with a duration of therapy limit of 6 weeks for fingernail infection and 12 weeks for toenail infection.

- Sporanox: For onychomycosis, there will be a quantity limit of 28 capsules per month (pulse therapy) with a duration of therapy limit of 2 months for fingernail infection and 3 months for toenail infection.

- Lamisil and Sporanox: An interval of 3 months will be required between the initial treatment of fingernail infection and a second treatment and an interval of 6 months between the initial treatment of toenail infection and a second treatment.

- Effective September 10, 2002, Penlac Nail Lacquer will require prior authorization in accordance with the following:

  - Approval of its use will be based on the presence of a medical contraindication to oral forms of Lamisil and Sporanox (e.g., liver or ventricular dysfunction) or drug interactions with Lamisil and Sporanox.

  - Effective September 10, 2002, griseofulvin products will be available without prior authorization.

- The following cost information based on Average Wholesale Price (AWP) is provided to show a relative comparison of the cost of drugs but does not represent the actual cost to Medicaid. Actual cost per day will be dependent on the daily dosage and frequency.

Brand Name	Strength	Dosage Form	AWP Per Unit
Griseofulvin Ultramicrosize	125 mg	Tablet	$0.34
Gris-PEG	125 mg	Tablet	$0.63
Griseofulvin Ultramicrosize	330 mg	Tablet	$0.89
Fulvicin U/F	250 mg	Tablet	$1.04
Gris-PEG	250 mg	Tablet	$1.25
Fulvicin U/F	500 mg	Tablet	$1.66
Grifulvin V	500 mg	Tablet	$1.75
Sporanox	100 mg	Capsule	*$8.50
Lamisil	250 mg	Tablet	$9.05
Penlac	8%	Topical Solution	$20.66

* Cost per day would be higher due to treatment with more than one capsule per day.

Drugs for Treatment of Migraine Headaches: Serotonin 5-HT_1 Receptor Agonists

- Effective September 10, 2002, Amerge, Axert, Frova, Imitrex (tablets and nasal spray dosage forms), Maxalt, Maxalt MLT, Zomig, and Zomig ZMT will be available without prior authorization subject to quantity limits, based on usual commercial packaging, in accordance with the following:

Drug	When Prior Authorization Is Required
Amerge 1mg & 2.5 mg tablets	If quantity exceeds 9 tablets per month.
Axert 6.25 mg & 12.5 mg tablets	If quantity exceeds 6 tablets per month.
Frova 2.5 mg tablets	If quantity exceeds 9 tablets per month.
Imitrex 25 mg, 50 mg, & 100 mg tablets	If quantity exceeds 9 tablets per month.
Imitrex 5 mg & 20 mg nasal spray	If quantity exceeds 6 unit dose sprays per month.
Maxalt 5 mg & 10mg tablets	If quantity exceeds 6 tablets per month.
Maxalt MLT 5 mg & 10mg tablets	If quantity exceeds 6 tablets per month.
Zomig 2.5 mg & 5 mg tablets	If quantity exceeds 6 tablets per month.
Zomig ZMT 2.5 mg & 5 mg tablets	If quantity exceeds 6 tablets per month.

  - Overrides to the maximum quantity will require documentation of migraine headache prophylaxis (e.g., beta-blocker, tricyclic antidepressant, calcium channel blocker, anticonvulsant).

- Effective September 10, 2002, Imitrex injection will require prior authorization in accordance with the following:

- Approval of its use will be based on a diagnosis of cluster headache or of migraine headache with intolerance to or failure of both oral and nasal forms of triptans (as listed above).

- Refillable prescriptions, which were written prior to September 10, 2002, may be refilled without prior authorization through November 30, 2002; however, prior authorization will be required thereafter.

- The following cost information based on Average Wholesale Price (AWP) is provided to show a relative comparison of the cost of drugs but does not represent the actual cost to Medicaid. Actual cost per day will be dependent on the daily dosage and frequency.

Brand Name	Strength	Dosage Form	AWP Per Unit
Axert	6.25mg	Tablet	$10.98
Axert	12.5mg	Tablet	$10.99
Frova	2.5mg	Tablet	$15.41
Zomig ZMT	2.5mg	Disintegrating Tablet	$15.94
Zomig	2.5mg	Tablet	$15.94
Imitrex	50mg	Tablet	$17.17
Maxalt	5mg	Tablet	$17.12
Maxalt	10mg	Tablet	$17.12
Maxalt MLT	5mg	Disintegrating Tablet	$17.12
Maxalt MLT	10mg	Disintegrating Tablet	$17.12
Imitrex	100mg	Tablet	$17.17
Imitrex	25mg	Tablet	$17.65
Zomig ZMT	5mg	Disintegrating Tablet	$18.13
Zomig	5mg	Tablet	$18.13
Amerge	1mg	Tablet	$18.46
Amerge	2.5mg	Tablet	$18.46
Imitrex	5mg	Nasal Spray	$22.93
Imitrex	20mg	Nasal Spray	$22.94
Imitrex	6mg/0.5ml	Vial	$53.59

Co-payments for Prescriptions

- As previously announced in Pharmacy Provider Letter #A-450, some Medicaid and KCHIP recipients are now responsible for a $1.00 co-payment for each prescription. Please refer to Pharmacy Provider Letter #A-450 for details about the co-payment requirements.

- Although the pharmacy must attempt to collect the co-payment, some individuals may be unable to pay the co-payment at the time the prescription is dispensed. Except pursuant to advance notice as described below, the pharmacy must not refuse to dispense the prescription, at the time it is presented, because an individual is unable to pay the co-payment or claims not to have the money for the co-payment. A pharmacy may refuse to provide future prescriptions to an individual who is unable to pay the co-payment or claims not to have the money for the co-payment only if the pharmacy provides the individual with advance notice.

Drugs for Nursing Facility Residents with Retroactive Eligibility Determinations

(applicable only to drugs for individuals in nursing facilities)

- The following clarifies the process for submitting requests for prior authorization for drugs which were administered in the interval between the date an individual was retroactively determined to be Medicaid eligible and the date of notification to the nursing facility that retroactive Medicaid eligibility was approved. When an individual in a nursing facility is determined to be retroactively eligible for nursing facility care, it is documented on the MAP-552 (Notice of Availability of Income for Long-term Care/Waiver Agency/Hospice) which is submitted to the nursing facility.

  - The applicable drug prior authorization request form must be completed and submitted.

  - It must be stated on the drug prior authorization request form that the request is for an individual in a nursing facility who has had an approved retroactive eligibility determination.

- The MAP-552 form (Notice of Availability of Income for Long-term Care/Waiver Agency/Hospice), which documents the date of retroactive eligibility, must be submitted as an attachment to the drug prior authorization request.

- When approved, the Start Date for the drug prior authorization will be the date of retroactive Medicaid eligibility as shown on the MAP 552 form.

Prescriptions Written by Advanced Registered Nurse Practitioners (ARNPs)

- Pharmacy claims for prescriptions written by advance registered nurse practitioners (ARNPs) are required to include the ARNP's registration number (including applicable alpha characters) and not the license number of the collaborating physician.

Drug Prior Authorization Request Forms

- There have been minor changes in the formatting of the drug prior authorization request forms. While current versions of the drug prior authorization request forms will still be acceptable, please begin using the revised forms which are enclosed with this provider letter.

- Copies of drug prior authorization request forms may be downloaded from the Medicaid web site at http://chs.state.ky.us/dms or call provider enrollment at 877-838-5085.

Nursing Facility Drug PA Fax Line

- Drug prior authorization requests for residents of nursing facilities should be submitted by fax to **(866) 863-9171**. Such requests will also be accepted if they are faxed to the general or urgent fax numbers shown on the drug prior authorization forms. The nursing facility fax line is intended to be used **only** for drug prior authorization requests for residents of nursing facilities.

Bulletin Board for Pharmacy Providers

- The Bulletin Board is a system that allows providers to look up NDC information as well as submit Medicaid EMC claims; download Remittance Advices; download file specifications; and download data entry software. Utilizing a dial-up connection from a computer system, the user can access these features 24 hours a day, seven days a week.

- The NDC lookup feature, which is updated monthly, allows users to search for NDC information using drug name or NDC number. This feature allows a pharmacy to verify whether a specific NDC number is covered without having to contact Provider Relations. Pharmacies can access this information by calling the EMC Help Desk (1-800-205-4696), obtaining an ID, and then logging on and navigating to the selection desired.

Requests for "Brand Name Only" When Generic Drugs Are Available

- A MAP-82101 (Brand Name Drug Request Form) or, if applicable, the brand name only section of a MAP-012802 (PPI and H2 Blocker Request Form) must be completed to request a brand name drug when the generic is available. Certain drugs which are temporarily exempt from this requirement are listed on the ***Brand Name Exempt List*** posted on Medicaid's web site at *http://chs.state.ky.us/dms/* (see Medicaid Drug Formulary under Pharmacy Program). Other PA requirements still apply.

Internet Web Site

- Medicaid's web site at ***http://chs.state.ky.us/dms/*** provides information about the Medicaid Pharmacy Program and related topics such as pharmacy provider letters, Pharmacy and Therapeutics Advisory Committee meetings and recommendations, Drug Management Review Advisory Board meetings and recommendations. You are encouraged to use this web site.

BRAND NAME
DRUG REQUEST FORM
(MAP-82101, revised 7/26/2002)

FAX to **866-863-8803** (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

Use this form to request a brand name drug when generic forms of the drug are available. Please provide medical justification why the individual can not be appropriately treated with the generic form of the drug.

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

	Brand Name Drug Requested (Use separate form to request more than 2 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA
1						
2						

	Has patient recently been treated with generic forms of the requested brand name drug? Circle yes or no. Specify dosage and length of therapy with generic forms.	Hand write "Brand Medically Necessary"	Prescriber Signature
1	Yes No		
2	Yes No		

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (Indicate why the individual's medical condition can not be adequately treated with generic forms of the drug.)

_____

_____

_____

_____

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	

DRUG PRIOR AUTHORIZATION REQUEST FORM

(MAP-82001, revised 7/26/2002)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to 866-863-8803 (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

_____

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

DRUG NAME (Use extra forms for more than 4 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
#1						
#2						
#3						
#4						

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (including drugs already tried) _____

_____

_____

_____

PHARMACY DISPENSING REQUEST: (Max. quantity override, replacements, etc.): _____

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	
DRUG #3	
DRUG #4	

PPI and H2 BLOCKER REQUEST FORM

(MAP-012802, revised 7/26/2002)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **866-863-8803** (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

Use this form to request proton pump inhibitors (PPIs) or H2 receptor blockers. **PROTON PUMP INHIBITORS:** Protonix does not require prior authorization (PA) if an individual has not had 12 weeks of therapy with PPIs in the past 6 months. Other PPIs require medical justification. All PPIs require PA for continued use beyond 12 weeks. **H2 RECEPTOR BLOCKERS:** Generic cimetidine and ranitidine do not require PA, but the others require PA with medical justification.

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

NAME OF DRUG REQUESTED	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)

Yes	No	Unknown	
[ ]	[ ]	[ ]	Is this a request for brand name only (if generic is available)? If yes, prescriber must hand write "Brand Medically Necessary" below and sign beside it.
[ ]	[ ]	[ ]	Has the requested drug been prior authorized previously?
[ ]	[ ]	[ ]	Has endoscopy or an esophagram been done? Give date of exam and results:

DIAGNOSIS (Check one)

- [ ] Barrett's esophagitis
- [ ] Duodenal ulcer, acute or recurring
- [ ] Esophageal stricture
- [ ] Gastric cancer, current or previous
- [ ] Gastric ulcer, acute or recurring
- [ ] GERD (Gastroesophageal reflux disease)
- [ ] GERD grade III-IV, continuing symptomatic
- [ ] GERD, atypical with chronic laryngitis, hoarseness, or cough due to reflux
- [ ] *Helicobacter pylori* eradication protocol
- [ ] NSAID gastropathy
- [ ] Schatzki's ring
- [ ] Zollinger-Ellison syndrome
- [ ] Other (specify)_____

PPI or H2 blocker Therapy (List all PPI's and H2 blockers used in the past 3 months.)	Dosage Form	Strength	Directions for Use	Date treatment started	Date treatment ended

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION _____

LEAVE THIS SECTION BLANK